STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155777	B. WING		08/16/2012	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
00540	, oppingo uz 41	T. I. O. A. A. E. I. O.		CREASY LN		
CREASY	SPRINGS HEALT	TH CAMPUS	LAFAY	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F0000	REGULATORY O	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE	
10000						
	This visit was f	For a Post Survey Revisit	F0000	The submission of this plan o	f	
		ecertification and State		correction does not indicate a		
	` ′	ey completed on June 28,		admission by Creasy Springs		
	2012.	e, compieced on cuite 20,		Health Campus that the findir		
	2012.			and allegations contained here are accurate and true	ein	
	August 15 & 16	5 2012		representations of the quality	of	
		0, 2012.		care and services provided to		
	Survey team:			Residents of Creasy Springs		
	Michelle Hoste	tar PN TC		Health Campus. The facilty maintains it is in substantial		
	Michelle Carter			compliance with the requirem	ents	
	Rita Mullen RN			of participation for comprehen		
	Kita Mulich Ki	•		health car facilities. This plan	of	
	Essilitz mumba	012205		correction will serve as the		
	Facility number Provider number			credible allegation of complia with all federal and state	nce	
	AIM number :			requirments governing the		
	Anvi numbei	201006770		management of this facility.		
	Census bed typ	e:				
	SNF: 45					
	SNF/NF: 18					
	Residential: 42					
	Total: 105					
	Census payor to	ype:				
	Medicare: 32					
	Medicaid: 4					
	Other: 69					
	Total: 105					
	Sample: 9					
	There 4. C.:	sian mada at atata Con Norma				
		cies reflect state findings				
	cited in accorda	ance with 410 IAC 16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905	1750 S CREASY LN					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE					
Quality review completed on August 22, 2012, by Bev Faulkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ISXG12

Facility ID: 012285

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING 00			COMPLETED	
		155777	B. WIN			08/16/2	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
CDEACY	SPRINGS HEALTH	LCAMBLIC			CREASY LN ETTE, IN 47905			
CREAST	SPRINGS REALT	1 CAIVIPUS		LAFATI	ETTE, IN 47905			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0309	483.25							
SS=D	PROVIDE CARE	SERVICES FOR						
	HIGHEST WELL							
		ist receive and the facility						
		necessary care and						
		or maintain the highest						
	practicable physic							
		being, in accordance with eassessment and plan of						
	care.	ve assessment and plan of						
		review and interview, the	F03	09	1. Resident number 36: Reside	ent	09/12/2012	
		·	103	0)	was assessed and left hip	CIIL	07/12/2012	
	_	assess the change in			incisions were noted to be			
		resident started on an			resolved with no red or open			
	antibiotic for a w	yound infection and a			areas observed. Resident			
	resident started of	on Pyridium for a spastic			number 48 was and continues	to		
	bladder. This eff	ected 2 of 9 residents			be assessed for bladder spasr			
	reviewed for asso	essments with a change			and effectiveness of medicatio	n		
		sample of 9. (Residents			ordered to treat bladder	41		
	#36 & 48)	sumple of 3. (Residents			spasms. 2. All Residents have potential to be affected by this			
	#30 & 40)				deficient practice. 3. Licensed			
					staff will be inserviced on the			
	Findings include				following:a. Facility's policy and	d		
					procedure for the proper			
	1. The clinical re	ecord of Resident #36			documentation on the MAR an	nd		
	was reviewed on	8/16/12 at 11:00 A.M.			PRN assessment form when			
					PRN meds are administered a	nd		
	Diagnoses includ	ded, but were not limited			for the proper documentation of	of		
	_				the wound care			
	to, dementia, dep	pression and renal failure.			sheet.b. Residents identified w	/ith		
					impaired skin have	.		
	A Hospital Disch	narge instruction form,			been assessed and appropriat documentation	l C		
	dated 7/16/12, in	dicated Resident #36 had			completed. Residents receiving	_a		
	under gone surge	ery for a fractured left			PRN medications will have a F	-		
	hip.	,			medication tracking log utilized			
	p.				conjuction with proper			
		1 1 1 1 7/20/12			documentation on the medicat	ion		
	_	der, dated 7/30/12,			administration record (MAR). 4			
	indicated "Keflex	x [an antibiotic] 500 mg			Medication adminstration reco	rds,		
	[milligrams] QII	D [four time a day] x 10			PRN tracking logs and wound			

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Event ID: ISXG12

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NAME OF PR	SUMMARY ST		A. BUII B. WIN	G	00	COMPLETED 08/16/2012
CREASY	SPRINGS HEALTH			G		08/16/2012
CREASY	SPRINGS HEALTH			_		
CREASY	SPRINGS HEALTH				ADDRESS, CITY, STATE, ZIP CODE	
	SUMMARY ST	I CAMPUS			CREASY LN	
(X4) ID		CREASY SPRINGS HEALTH CAMPUS			ETTE, IN 47905	
	(EACH DEFICIENCE)	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG				TAG	,	DATE
TAG	A Narrative Nurs at 4:10 P.M., ind physician): rednessites et (and) ord physician) was ir [increased] s/s [s infection." An "Infection As dated 7/31/12, in Reddened wound wound]. Wound periarea warm/ho required: yes. MI QID x 10 days form, consisted of 7/30/12 to 8/9/12 for a total of third check lists indicated as a second control of the contr	LSC IDENTIFYING INFORMATION) /12) and notify surgeon." sing note, dated 7/30/12 icated "Notified [name of ess, swelling @ incision er from (name of nformed to watch site for ign and symptoms] of seessment and Review," dicated "Wound left hip. If periarea [around the drainage. Wound of to touch. Treatment D orders Keflex 500 mg "Follow- up on the of check lists from to one box for each shift try check list boxes. The atted the following: 8/9/12: The recorded		TAG	skin sheets will be audited for accurracy 3 times a week for 4 weeks then weekly times 4 we then monthly times 4 months pure the Director of Health Services and or designee. Audits will be reviewed monthly for 6 months QAA commitee.	eks eer
	temperatures ind not running a fev	icated Resident #36 was eer.				
	7, 8/ and 9, 2012 description of the amount of rednes pain. On August "Symptoms Reso	ving: August 1, 2, 3, 4, 6, . There was no e wound regarding the ss, drainage, swelling or 5, 2012, the box for olving" was not checked. Nursing Assessment and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155777	B. WIN			08/16	/2012
	PROVIDER OR SUPPLIER			1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	I IE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	Data Collection"	form, dated 7/31/12,					
	8/2/12 and 8/7/1	2, (for a total of three					
	· · ·	, indicated the skin was					
	· ·	ne color was natural, no					
	-	and had no dressing.					
		ention or description of					
	•	nd nor was there an					
		e wound after the					
	antibiotic was co	ompleted on 8/9/12.					
	During an interv	iew with the Director of					
	Nursing, on 8/16	5/12 at 1:50 P.M., she					
	•	und sheets, which are					
		d/treatment book, would					
	•	iption of the wound on					
	Resident #36's le	•					
	The "Wound/Tre	eatment Book" was					
		e Director of Nursing, on					
		P.M. There were no					
		the Wound/Treatment					
		tor of Nursing indicated					
		sments should have been					
	in the book.						
		ecord of Resident #48					
	was reviewed on	8/16/12 at 9:00 A.M.					
	Diagnoses for Re	esident #48 included, but					
	_	to, neurogenic bladder,					
	anxiety and insor	_					
	A Physician's fay	x form, dated 7/27/12,					
		Resident] c/o [complaints					

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Event ID: ISXG12

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If continuation sheet

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE CO A. BUILDING B. WING			COMPLETED	
	PROVIDER OR SUPPLIEF		STREET A 1750 S	DDRESS, CITY, STATE, ZIP O CREASY LN ETTE, IN 47905	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	bladder sometime extreme pain) et PRN [as needed responded on 7/2 pyridium (an anturinary tract) 20 (every) 8 (hours) A review of Nurthrough 8/9/12, 4/48 was having spasms.	sing notes, 7/27/12 did not indicated Resident problems with bladder				
	Assessment and 7/29/12 through Resident #48 was bladder, used the and the urine was	"Skilled Nursing Data Collection," dated 7/31/12, indicated as continent of bowel and to toilet for elimination as yellow and clear. were not addressed on the				
	indicated Pyridic time a day) x 3 c A "Skilled Nursi Collection," date Resident #48 w and bladder, had the toilet for elin was clear and or	der, dated 8/1/12, um 200 mg TID (three days then TID PRN. ang Assessment and Data ed 8/1/12, indicated as "continent of bowel doverflow of urine, used mination and the urine ange due the pyridium sident #48 complaint of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETE	
		155777	B. WIN	IG		08/16/201	2
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
00540					CREASY LN		
CREASY	SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN 47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	not voiding. An						
		ollected 500 cc (cubic					
	· · · · · · · · · · · · · · · · · · ·	elear, orange urine. The					
	_	were not addressed on the					
	assessment.						
	An "Elimination	-					
		nd Intervention" form,					
		licated an I & O cath for a					
	neurogenic blade	-					
	incontinence or retention of urine). The						
		ip form, consisted of					
		from 8/1/12 to 8/4/12;					
		shift for a total of nine					
	check list boxes.	The check lists indicated					
	the following:						
	8/1/12, 2 to 10 sl	hift: Continent of bowel					
	and bladder, I &	O monitoring and no					
	difficulty voiding	g.					
	8/2/12, 10 to 6 sl	hift: Continent of bowel					
	and bladder, I &	O monitoring, no					
	difficulty voiding	g and normal bowel					
	movements.						
	No date or time	on entry: I & O					
	monitoring, 550	cc.					
	_						
	8/2/12, 2 to 10 sl	hift: Continent of bowel					
	·	O monitoring and no					
	difficulty voiding	_					
		<u>C</u>					
	8/3/12, 10 to 6 sl	hift: Continent of bowel					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/16/2012		
	PROVIDER OR SUPPLIER			1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and bladder and	no difficulty voiding.					
	8/3/12, no shift i continent of bow	ndicated: Resident vel.					
	8/3/12, no shift i box was blank.	ndicated: The check list					
	•	hift: Continent of bowel O monitoring and ist.					
	and bladder, I &	hift: Continent of bowel O monitoring, toileted ericare completed.					
	shift on 8/4/12, r	regarding the neurogenic r spasms were not assessments.					
	Collection," date Resident #48 wa bladder, wore br elimination and orange due the p	ang Assessment and Data ed 8/5/12, indicated as continent of bowel and iefs, used the toilet for the urine was clear and yridium medication.					
	(MAR), dated for 2012, indicated l	dministration Record or the month of August Resident #48 had m 200 mg TID for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/16/2012
	PROVIDER OR SUPPLIEI		1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
	starting on 8/1/1 and ending on 8 Resident #48 rec 8/10/12, 8/14/12 the MAR indica were to have the should be noted notes. The back During an interv 8/16/12 at 3:00 medications are medication sheet the medication as sheet. The PRN for August 2012 #1 on 8/16/12 at sheet did not increceived pyridiu month of Augus assessment regar for bladder spass During an interv Nursing on 8/16 indicated the "E Reassessment at dated 8/1/12, was The resident had hospital and war	routinely for three days 2 with the evening dose /4/12 with the noon dose. Decived PRN doses on 2 and 8/16/12. The back of ted PRN medications are reason given and results on Nurse's Medication of the form was blank. Wiew with LPN #1, on P.M., she indicated PRN documented on the PRN and the assessments for are done on the PRN medication sheet, dated 2, was reviewed with LPN at 3:10 P.M. The PRN dicate Resident #48 had are 200 mg during the at 2012. There was no rading the use of pyridium ms. Wiew with the Director of 1/12 at 1:00 P.M., she limination Circumstance, and Intervention" form, as the bladder assessment. If been on pyridium at the inted to be back on the why the physician wrote			

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777 A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/16/2012				
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN				
CREASY	SPRINGS HEALT	H CAMPUS	LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	This deficiency 2012. The facili	was cited on June 28, ty failed to implement a f correction to prevent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155777	B. WIN			08/16/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	CREASY LN		
CREASY	SPRINGS HEALTH	H CAMPUS			ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=F	483.35(i) FOOD PROCURI						
		E/SERVE - SANITARY					
	The facility must -	rom sources approved or					
		actory by Federal, State or					
	local authorities;						
	(2) Store, prepare under sanitary co	e, distribute and serve food nditions					
	Based on observa	ation and interview, the	F03	71	1. Areas cited during survey w	ere	09/12/2012
	facility failed to	ensure shelving units			cleaned on 8/16/12. Food not		
	were clean, hairn	nets were worn as			properly labeled was destoyed		
	required and pro	per food labeling and			All residents have the potentia be affected by this deficient	I (O	
		leficiencies had the			practice.3. Entire kitchen was		
	_	et 92 of 92 residents who			deep cleaned on 8/30/12 with		
	•	om the main kitchen.			direction and assistance of hor		
					office Dining Services staff. Or	1	
	Findings include	:			9/7/12, Dining Services home office support held a directed		
					inservice for all dietary staff.		
	During the main	kitchen tour on 8/15/12			Areas covered were kitchen		
	at 10:30 A.M., th	ne following were found:			sanitation and cleaning schedules, proper labeling and	ı	
		-			storage of opened food, and	•	
	In the walk-in fro	eezer: An open box (lid			facility policy for wearing hair		
		f 20 individual breaded			nets/hats in kitchen. All staff w	ill	
	-	were found without a			be inserviced on hair net/hat		
	*	and were not covered.			policy by 9/12/12 by Dining Services home office support.		
	umic of optiming t				Acting DFS, ADFS, closing		
	In the walk-in re	frigerator: Sixty (60)			chef, and dietician will audit		
		s and cottage cheese were			kitchen sanitation by verifying		
	-	on trays and not dated.			cleaning tasks were completed Audits completed 5 days/ week		
		iew with the morning			Dietician will review with QA&A		
	-	she said the dishes of			committee results of audits/iss		
	-	age cheese were going to			in dining services.		
	-	dents at lunch that day					
		ndicated the food items					
	` ′						
	needed to be date	ed and covered, but she	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155777	B. WIN			08/16/2012	
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			CREASY LN		
CREASY	SPRINGS HEALTI	H CAMPUS			ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDEDIS DI ANI OE CODDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	had not had time	e to do so.					
	On 8/16/12, duri	ing an interview with the					
	Director of Food Services (DFS) at 2:40						
		ted all opened items					
		-					
		opening and a label for					
		dicated she was at a					
	_	on 8/15/12, but the					
		ould have dated and					
	labeled these iter	ms. She confirmed the					
	main kitchen ser	ves the health care					
	residents and the	e assisted living residents.					
	During the main	kitchen tour on 8/15/12					
		the following was					
	•	of 4 stainless steel					
		nters were dusty and					
		. The stainless steel shelf					
	_	ras dirty, sticky, and					
	_	h receptacles were found					
		ds in these areas: to the					
		outside the walk-in					
	freezer, at the ea	st end of a stainless steel					
	counter, and at the	he 2-compartment sink					
	next to the hand	washing station. At the					
		these trash receptacles					
	were not in use.	•					
	During the main	kitchen tour, at 10:30					
	_	ng chef was having a					
	· ·	th the Social Services					
		The SSD was not					
	-	et. The two employees					
	were standing 1	12 inches (9 feet, 4					

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Facility ID: 012285

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00			COMPLETED		
	155777		B. WING			08/16/2012		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAIME OF PROVIDER OR SUPPLIER			1750 S CREASY LN					
CREASY SPRINGS HEALTH CAMPUS				LAFAYE	ETTE, IN 47905			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE COMI		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	inches) from the kitchen door.							
	During an interv	iew with the DFS on						
	8/16/12 at 2:40 F	P.M., she indicated there						
	was tape on the l	kitchen floor to determine						
	how far an emple	oyee could go into the						
	kitchen without	wearing a required						
		or tape was measured and						
		56 inches (4 feet, 8						
	inches) away fro	· ·						
	The DFS, also, indicated that she had							
	created a cleaning schedule for the cooks							
	and dietary aides to follow. The cooks							
	and aides were to make a handwritten							
	checkmark next to the task listed after it was completed/cleaned. Additionally, she							
		•						
	indicated some tasks were not completed/cleaned, as they should have been, according to the cleaning check lists from 7/30/12 to 8/12/12.							
	TEL: 1.C							
	This deficiency was cited on June 28, 2012. The facility failed to implement a systemic plan of correction to prevent							
	recurrence.							
	3.1-21(i)(1)							
	5-5.1(f)							

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Event ID: ISXG12

Facility ID: 012285

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
	155777		B. WIN			08/16/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1750 S CREASY LN			
CREASY SPRINGS HEALTH CAMPUS			LAFAYETTE, IN 47905				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFINITION OF LIGHT STATEMENT OF THE STATEMENT			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0465	483.70(h)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	 	DATE
SS=D	SAFE/FUNCTION TABLE ENVIRON The facility must p sanitary, and com	SAFE/FUNCTIONAL/SANITARY/COMFOR FABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.					
	Based on observation and interview, the facility failed to		F04	65	Kitchen floors were cleaned 8/16/12, 2, All residents have t	the	09/12/2012
					potential to be affected by this		
	ensure the fl	oors of the main			deficient practice.3. Kitchen flowere deep cleaned on 8/30/12		
	kitchen floor	rs were clean and			Acting DFS, ADFS, closing		
	free of debri	s for 1 of 1 kitchen			chef, and dietician will audit kitchen sanitation and floor		
	observed.				care/cleanliness by verifying fluction	oor	or
	on 8/15/12 a main kitcher	elude: main kitchen tour at 10:30 A.M., the h's floor was not es were dirty, dusty,			were followed. Audits completed 5 days/ week. Enviormental services will schedule kitchen floor deep cleaning quarterly4. Dietician verview with QA&A committee results of audits/issues in dinir services, including floor care.		
		food crumbs and					
		red. There were					
		lroplets and clear					
	fluid spillage	-					
	Tiala Spilias						
	floor was sti	orage room, the cky with noted, ime and debris.					

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Event ID: ISXG12

Facility ID: 012285

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155777		A. BUILDING B. WING		08/16/2012	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
CREASY SPRINGS HEALTH CAMPUS				CREASY LN ETTE, IN 47905	
(X4) ID			ID	ETTE, IN 47905 T	(X5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG			TAG	DEFICIENCY)	DATE
	On 8/16/12,	durino an			
	1	ith the Director of			
		tes (DFS) at 2:40			
		dicated new floor			
	ĺ	oducts were ordered			
	but had not arrived, yet. Additionally, she (the DFS)				
	1	e created a cleaning			
		•			
	schedule for the cooks and dietary aides to follow. Floor				
	cleaning (mopping and using a				
	deck brush) was included on				
	· · · · · · · · · · · · · · · · · · ·				
	the schedule. The cooks and aides were to make a				
	handwritten checkmark next to				
	the task listed after it was				
	completed/cleaned. Additionally, she indicated				
	some tasks	•			
		eleaned, as they			
		•			
		been, according to			
	the cleaning check lists from 7/30/12 to 8/12/12. She				
	confirmed t	he main kitchen			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	NG	00	COMPL	ETED		
		155777	B. WING	10		08/16/	2012	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		II	D	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE	
	serves the health care residents							
	and the assisted living							
	residents.							
	3.1-19(f)							
	5-1.5(k)							
	` ,							
F9999								
			Facco				00/10/2010	
			F9999		No information has been provi- for this area. All previous citati- other than 2 were cleared. I an responding only because I am unable to close and submit if I not.	ons n	09/12/2012	

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Event ID: ISXG12

Facility ID: 012285

If continuation sheet

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